Interim Report on Serious Reportable Events in Massachusetts Hospitals

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Agenda

I. Introduction
II. Data
III. Challenges
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I. Introduction

- The Department's new National Quality Forum-based system for serious event reporting was implemented in January, 2008.
- All licensed hospitals in Massachusetts are required to report any occurrence of a Serious Reportable Event (SRE).
- The system was developed with extensive consultation with the Board of Registration in Medicine, the Massachusetts Hospital Association, and numerous other stakeholders.

I. Introduction

- The interim report is based upon 6 months of data (January – June, 2008).
- This is considered the start-up period, so we are cautious about drawing any conclusions from the data.
- Data is reported in aggregate, not by individual hospital.

II. Data

- During the first half of 2008, Massachusetts hospitals reported 205 serious reportable events.
- Seventy-seven percent of these were related to patient falls, and six of these contributed to the patient's death.

II. Data

Specific Serious Reportable Events in Massachusetts Hospitals:
January 1, 2008 – June 30,2008

Event Type	Number of Events	Percent of Total Events
Patient Fall	158	77%
Medication Error	10	5%
Retained Foreign Object Following Surgery	10	5%
Wrong-Site Surgery	9	4%
All Other	18	9%
Total	**205**	**100%**

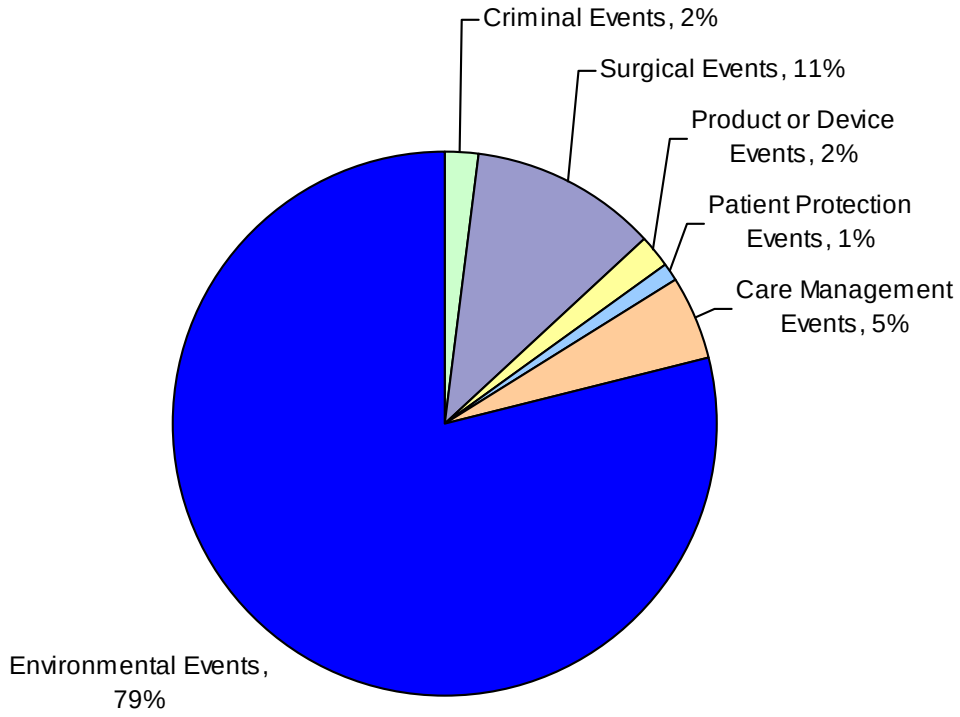
II. Data

The 28 discrete adverse medical events that must be reported are grouped into six major categories:

- Surgical related events.
- Product or device related events.
- Patient protection related events.
- Care management related events.
- Environmental events.
- Criminal events.

II. Data

Distribution of Serious Reportable Events in Massachusetts Hospitals: January 1, 2008 – June 30,2008



Environmental events account for 79 percent of the total SREs reported.

II. Data

- Using annualized SREs and 2006 patient days, an aggregate statewide SRE rate for acute care hospitals of only 8.49 events per 100,000 patient days was calculated.
- In the future, it will be instructive to compare categorical SRE rates controlling for demographic differences and other characteristics.
- Currently, the NQF categories have to be adjusted in order to have a basis for comparison with other states.

II. Data

Multistate Comparison of SRE Rates
with MA Rates Adjusted for Comparison[1]

	MA[2]		MN[3]		IN[4]	
SRE	#	Rate*	#	Rate*	#	Rate*
Surgical Events	44	1.09	60	2.14	45	1.1
Product or Device	8	0.2	5	0.18	2	0.05
Patient Protection	4	0.1	3	0.11	2	0.05
Care Management	22	0.55	49	1.75	38	0.93
Environmental	16	0.4	4	0.14	5	0.12
Criminal	12	0.3	4	0.14	9	0.22
Total	106	2.63	125	4.46	101	2.47

***SRE count/100,000 patient days**

This chart illustrates one way in which the data could be used for comparison… but no conclusions should be drawn from this chart

[1] The 152 non-fatal falls were excluded to make the NQF event category data comparable with the recently reported Minnesota and 2007 Indiana data
[2] Massachusetts Department of Public Health/Division of Health Care Quality, 2008
[3] www.health.state.mn.us/patientsafety/ae/aereport0108.pdf
[4] www.in.gov/isdh/files/2007_MERS_Report.pdf

III. Challenges

- It is difficult to draw meaningful conclusions from 6 months of data.
  - Limited sample size.
  - Data collected for the first time using new criteria.
  - Criteria are not reliably interpreted consistently by all reporting organizations.
- There is no completely comparable available data for benchmarking.
- However, the data collection system itself is working and communication between reporting institutions and the Department continues to be excellent

IV. Next Steps

- Full-year hospital specific data will be published in March of 2009.
  - DPH website
  - QCC website
- Data will be updated on an annual basis.
- Data will be published by hospital, with the format to be determined with your help

IV. Next Steps

- Collection of race and ethnicity began last August. The DPH/DHCFP categories were used and we are working with the hospitals to ensure they are reported correctly.
- We will report on analyses of events by race, ethnicity, age, gender, and other measures in the first annual report.

IV. Next Steps

- Training and education with the hospitals is ongoing.
- Actions that could potentially be taken when an unusual cluster of events is seen at a hospital over a period of time need to be discussed.